NH EMS MEDICAL CONTROL BOARD

Fire Standards and Training and Emergency Medical Services
Concord, NH

MINUTES OF MEETING

March 20, 2008

Members Present: Donavon Albertson, MD; Tom D'Aprix, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Jim Martin, MD; Douglas McVicar, MD; John Sutton, MD; Sue Prentiss, Bureau Chief

Members Absent: Chris Fore, MD; Jeff Johnson, MD; Joseph Mastromarino, MD; William Siegart, DO; Norman Yanofsky, MD

Guests: Steve Erickson, Jeanne Erickson, Doug Martin, Michael Pepin, Jonathan Dubey, David Dubey, Chris Dubey, Janet Houston, Eric Jaeger, Kevin Drew, Janet Williamson, Shawn Riley, Eric Schelberg, Steve L'Heureux, Dave Tauber, Steve Achilles

Bureau Staff: Rick Mason, Director, Vicki Blanchard, ALS Coordinator, Kathy Doolan, Field Services Coordinator, Eric Perry, Education Coordinator, Mike Schnyder, Research and Quality Management Coordinator

I. CALL TO ORDER

McVicar welcomed all to the meeting, and asked for everyone in the room to introduce themselves.

EMS Community. No report

Acceptance of Minutes. January 17, 2008 minutes were already approved via email.

II. DISCUSSION AND ACTION PROJECTS

Item 1. NH E911 Update: Steve L'Heureux, from NH Bureau of Emergency Communications (NH E911), reported about the progress of the EMD system. Compliance to protocol is still above 90%. L'Heureux's main reason for being here is to announce to the Medical Control Board that NH E911 would be rolling out Version 11.3 of The National Academy of Emergency Medical Dispatching (EMD) guidelines. The update will bring changes including the latest AHA standards. For example, AED use for patients one year old or greater, as opposed to the old standard of older than eight years. For routine CPR, the dispatchers will be instructing bystanders to begin with compressions over ventilations. However there are alternate pathways for specific instances in

which the dispatchers may instruct the bystander to begin with ventilation, such as in the case of a drowning. Also, there is the option for a provider who refuses to perform mouth-to-mouth, in which case the bystander will be advised to perform compressions only. Additionally, the dispatchers will be advising chest pain patients to take aspirin. For patients with signs of a stroke, the dispatchers will try an ascertain from the caller how long ago the patient's signs and symptoms started.

Discussion:

- Albertson asked how many other people are using the Priority Dispatch System, to which L'Heureux answered that there are approximately 3,800 centers in 13 countries, and in 8 languages.
- Lanzetta inquired about the aspirin administration guidelines, to which L'Heureux replied that he would send a copy to the Board.
- D'Aprix inquired about the two-hour decision for stroke patients, specifically why two hours? McVicar stated that he picked this number based on average response times. D'Aprix asked if the idea was that if more than two hours have passed by the time of the call, then there is no chance for the patient to be transported, evaluated, CT completed, and treated within three hours. McVicar said different localities may have different response times, so he wouldn't say there was "no chance", but this seemed a reasonable data point to work from. D'Aprix said rather than set any amount of time, he would like to know the time of onset of the symptoms. L'Heureux stated that dispatchers are more likely hear "within the last hour" not "12:30." In any case, the amount of time does not drive a different response. It does not change the Determinant Descriptor except to add a suffix. The information is intended to be useful downstream, but the biggest problem is that local dispatch agencies around the state are not passing the information along. There was no comment from the Board requesting that a time other than 2 hours be utilized.
- Lanzetta asked if there was a liability in instructing a caller to take a medication (aspirin). L'Heureux replied that they are comfortable with the protocol as it is written, currently it has been used at other centers without any reported adverse side effects. However NH E911 will follow what ever the Medical Control Board wants them to do. No one on the Board expressed an objection to the pre-arrival aspirin process as presented.
- Albertson asked about syndromic surveillance software. L'Heureux replied that First Watch, a syndromic surveillance product, is being evaluated by the Bureau of Emergency Communication. He will get information about this product to the Board.
- McVicar asked if there were any updates regarding cell phone location by GPS. L'Heureux replied that in spite of progress it is still a "great challenge." The continuing delays are not on E911's end, but due to the local telephone companies. The new highway markers have been helpful as an alternative to GPS for some callers.
- D'Aprix asked about another technology related problem: locating people who call 911 from their computers using VOIP (Voice Over Internet Protocol). L'Heureux reported that this is not his specialty, but he does not believe there is any answer for this yet.

Decisions: Discussion and update only, no formal decision required.

Item 2: NH Medicaid Ambulance Certifications

Chris Stawasz from Rockingham Ambulance and Tom D'Aprix presented the Board with a "Summary of NH Medicaid Ambulance Billing Documentation Requirements." Their presentation outlined the fact that NH Medicaid is the only Medicaid provider in America to still require ambulance certification for emergency ambulance trips. All other states follow the Centers for Medicare and Medicaid Services (CMS) ambulance billing rules, which do not require the ambulance certifications.

Discussion:

- D'Aprix stated that NH Medicaid wants a signature on every single patient coming through the emergency department declaring it was medically necessary for the patient to go to the hospital. This is a problem since we are being asked to sign the document before we have even seen the patient. If you wait until after you have seen the patient, then there is the issue of matching up the necessity form with the correct EMS records and getting it back to the transporting service. In the larger hospitals this has become very difficult. Additionally, EMS does not have a way to say, "No, we are not taking you to the hospital, because it is not medically necessary." Additionally, Medicare (CMS) does not require these signatures. NH Medicaid forms state that they follow CMS guidelines, but then you read down a few paragraphs to find that signatures are required.
- Lanzetta described this as a "Catch-22" situation. A layperson thinks they are having an emergency, and EMS must transport them. Yet Medicaid can refuse to pay. This puts the physician right in the middle.
- Stawasz addressed the Board. He said that Rockingham Ambulance is the largest EMS Provider in the state. Many times what a prudent layperson considers an emergency may not be considered an emergency by a health care professional. Then Medicaid will refuse payment, and the ambulance service is barred from billing the patient – even though the ambulance had no choice but to transport the patient. Stawasz feels that as Medicare moves forward with "Recovery Audit Contractors" (RACs) -- who are paid a percentage of billing errors they find -- there may be potential for hospital fees and physician fees to be withheld, not just ambulance fees, in any case where the retrospective determination is that an emergency condition did not exist.
- McVicar inquired what happens if the forms are not signed. Are there penalties? To this Stawasz replied that there are no penalties, just the loss of Medicaid payment and being barred from billing the patient. McVicar then observed that Medicaid payments are just a fraction of Medicare payments, and asked if the Medicaid pittance was worth going after. Stawasz replied that in health care every dollar counts. He pointed out that diesel fuel is over $4 a gallon.
- McVicar asked what ambulance providers are you looking for from the MCB? Stawasz and D'Aprix agreed they would like to see endorsement

from the MCB to ask NH Medicaid to follow the CMS guidelines and not require the signatures.

- Hubbell replied that he felt it was appropriate for MCB and ACEP to let NH Medicaid know this was becoming problematic.
- Chris Dube, from the NH Ambulance Association, stated that he agreed with Stawasz. He added that it had not been a discussion with the ambulance association, but after today's meeting he would certainly bring it up.
- Odell asked who in state government did Medicaid fall under, to which Prentiss stated NH Health and Human Services (HHS).
- Prentiss suggested that the MCB and the Coordinating Board write a letter to the new Health Commissioner, Nicholas Toumpas, highlighting this problem. An appropriate way to ensure appropriate attention to the letter might be to approach the Commissioner of Safety and have him speak with the Commissioner of HHS.
- D. Martin suggested taking this to the Coordinating Board to see if they would be willing to support it as well.

Decision: McVicar to draft a letter and send it to the MCB, Coordinating Board, Stawasz and Dube for review; then ask Mason to present it to the Commissioner of Safety. The Board agreed unanimously.

Item 3. Transfer Algorhythm

On behalf of the NH Interfacility Transfer Task Force, Odell informed the MCB that the task force has been working on an algorhythm to match the needs of the interfacility transfer patient with the proper EMS resource, particularly paramedics. He explained that often the physician sending the patient requests a paramedic even when the condition of the patient does not warrant paramedic level care. This means the community loses paramedic coverage for a number of hours. The task force is working to make sure that the paramedic is requested when clinically indicated, but not when an EMT Intermediate or Basic would be safe. Odell explained further that he is here today to ask for a few members of the MCB to look at the draft algorithm and make suggestions for improvement. They could work on this via the internet and email. Once the task force is satisfied they would present it to the MCB for endorsement.

Discussion:

- J Martin inquired as to where the problem lay. Was it ED to ED, or ED to hospital, or inpatient transfers? Odell stated that non-emergency physicians sending from ICU were more of a problem than emergency physicians. J Martin responded by asking if that was due to an education problem, where family physicians do not know the difference between a basic, intermediate or paramedic? Odell: Yes, this could be the case.
- J Martin continued to state that sending physicians must keep in mind EMTALA and the "potentially" unstable. It can be seen as the "patient we have, versus the patient we 'might' have" if something goes wrong and the patient's condition deteriorates. This may justify sending a paramedic with a stable patient as a precaution.
- Odell explained that the task force is not creating this document as a protocol that must be followed, but instead as a document that could be used in an education/training/quality management effort.

- Tauber added that NH was the only state that does not facilitate reimbursement at the higher Medicare rate called the "Specialty Care Transport Rate". This higher reimbursement could be helpful in making ALS personnel more available for this type of transfer. Our protocols could be modified to support this level of reimbursement.

Decision: J Martin, Lanzetta and McVicar agreed to be on a subcommittee to assist the task force. Odell will set up telephone and/or email meetings.

Item 4. Protocols

Blanchard and D'Aprix presented the Board with a power point survey of the 11 protocols worked on by the Committee. D'Aprix stated that many of these were so well-written in the last edition that no changes at all were needed.

Protocols with no changes:

- Gum Elastic Bougies
- Orotracheal Intubation
- Advanced Suctioning
- Tracheostomy Care
- Advanced Spinal Assessment
- Vascular Access via Central Catheter
- Crime Scene/Preservation of Evidence
- On-Scene Medical Personal

Protocols with minor grammatical or formatting changes:

- Apparent Life-Threatening Event (ALTE)
  - Moved out of Routine Patient Care to its own protocol
- Thoracic Injuries
  - Added bullet stating, "Do not splint the chest"
- Nasotracheal Intubation
  - Removed redundant pediatric contraindication
- Umbilical Vein Cannulation
  - Grammatical changes only
- Cyanide Poisoning
  - Reformatted with boxes similar to Organophospate protocol

Discussion on Cyanide Poisoning:

- McVicar stated that his memory is that when the Board wrote the cyanide protocol with both the old Lilly Kit (nitrites and sodium thiosulfate) and the Cyanokit (hydroxocobalamin) the plan was to phase out the old Lilly Kit with this version of the protocols. D'Aprix replied that he did not think two years was enough time but we could certainly change the protocol. McVicar stated he would like to see the Lilly kit removed from the protocol, and strongly nudge everyone towards the vastly superior treatment, the Cyanokit. D Martin reminded the Board that there may be facilities that still have only the Lilly kit – some of these are manufacturing facilities, not just medical. McVicar replied that the Board had no oversight responsibility for industrial facilities unless they use licensed EMS providers.

- Albertson stated that the Lilly kit's shelf life was 18 months and the Cyanokit was 30 months. So the Lilly kits will expire and have to be replaced. We would like to ensure they are replaced with Cyanokit.
- J Martin stated that he did not think all facilities were switched over to the Cyanokit and we should allow for the Lilly kit in the protocols.
- Hubbell was interested to know what industrial sites were using for kits and inquired if the Fire Academy knew what fire services were doing. No one had this information.
- D'Aprix stated that he just received concerns from the Poison Center to which he had not had a change to review prior to the meeting.
- Sutton stated that he felt the protocol should emphasize the Cyanokit, however there should be something in there that states if you do encounter the Lilly kit here is what you do.
- McVicar concluded that there were many pending questions. He asked if Schnyder could look at TEMSIS and if Bill Wood could find out who in the fire service was using the Lilly kit versus the Cyanokit.

Decision: Schnyder will investigate the use of the Lilly kit and Cyanokit throughout NH, at the May meeting we will revisit the protocol.

Continuation of Protocols Review:

- Rapid Sequence Intubation:
    - Maximum doses added: Etomidate (40 mg) and Succinylcholine (150 mg)

Discussion on maximum doses:

- Albertson asked if other protocols had maximum doses, to which it was replied, yes a number of them do.
- Lanzetta thinks maximum doses a good idea. Even if the patient is obese, that won't require exceeding the maximum dose because, pharmacologically, the recommended doses of these two agents are not highly body-weight dependant.

Discussion on Cricoid pressure:

- Sutton stated that cricoid pressure should continue until 'proof of placement'. The current wording of the protocol suggests that cricoid pressure be discontinued after balloon inflation. But if there is an esophageal intubation, the airway isn't protected

Decision: Change the cricoid pressure bullet so pressure will be maintained until proof of placement. No objection from the Board.

Continuation of Protocol Review:

- Blind Insertion Airway
    - Removed individual protocols for Combi-tube, King LT-D, and LMA and created a single generic blind insertion airway protocol

which states “see manufacturer’s instructions” for individual products.

Decision: No objection from the Board.

Continuation of Protocol Review:

- Cricothyrotomy
    - Per the National Scope of Practice Model the subcommittee asks the MCB to consider removing surgical crics from the paramedic scope of practice. Additionally, suggest no needle cricothyrotomy except using a standard commercial kit.

Discussion::

- Blanchard reported that according to Tammy Fortier most ambulances Tammy inspects do not have homemade needle cric kits, but stock a commercial product (including a Melker Kit which includes a scalpel just for making a nick in the skin to introduce the needle.)
- Albertson asked the people in the room when was the last time they did a surgical cricothyrotomy. Riley stated that he has done it before and it is a “pretty easy skill.” Pepin agreed. Lanzetta asked if any of these patients survived. Follow-up was not known for all the patients. But in those cases where the result was known, all died.
- McVicar asked Albertson what he thought now that his question has been answered. Albertson replied that he believes that the procedure is indeed quite easy – for people who do a lot of them. Moreover, the surgical procedure is easier than the needle procedure.
- Sutton agreed with Albertson. He does a fair number of these procedures and he trains residents in the procedure. For people who do the procedure a lot, it is his personal experience that the surgical cricothyrotomy is almost easier. But in the setting of people who don’t do either one very frequently Sutton thinks both are very hard.
- Prentiss suggested tabling the final decision until we talk with the Scope of Practice national authors and see why they made the change. Albertson agreed as there was no urgency for a decision today.

Decision: Schnyder is to see how often surgical crics are being performed, and try to assess the results. Prentiss and Blanchard will find out from the authors of the Scope of Practice why they removed the surgical cricothyrotomy skill.

Continuation of Protocol Review:

- Special Resuscitation Situations and Exceptions
    - Reformatting and re-ordering of information. “Signs of Death” updated and “Factors of Death” added. Additionally, following the new AHA standard, we added that EMS providers were not required to transport every victim of cardiac arrest to a hospital. Additionally, keeping in mind the risk involved to the EMS provider of performing resuscitation efforts in the back of a moving ambulance, the protocol was updated to reflect AHA’s

recommendation that “it is expected that most resuscitations will be performed on-scene until return of spontaneous circulation or a decision to cease resuscitation efforts is made based on the criteria listed under “When to Stop””.

Discussion:

- There were concerns with leaving a body at the scene. Pepin stated that to leave a body in a home was not really an issue, but the situation is quite different in the aisle of Wal-Mart. Pepin believes that if you stop resuscitation efforts, the scene now becomes law enforcement’s and a medical examiner is required. There were then questions as to who can call the medical examiner, EMS or police.
- Riley reminded us that EMS created artifact during resuscitation attempts, and that by moving a body we have destroyed an incredible amount of evidence.
- Prentiss explained that while it has occurred that the medical examiner has asked EMS providers to move a body to the hospital, actually the funeral directors are the ones who have the authority to move a body.

Decision: There being no objection, the changes are approved as written.

Continuation of Protocol Review:

- Refusal of Care
    - Reformatting for ease of reading.

Discussion:

- Albertson commented on the second sentence under competency definition. He felt it was an extremely high standard to have in the field. The sentence reads, “Adult patients that are (age 18 or older) that are legally, mentally, and situationally competent, reserve the right to refuse care and or transportation.” How could a field provider who is not a judge make this determination? He would like to lose the sentence.
- McVicar concurred with Albertson stating if we leave the sentence, we need to define each term in that list.

Decision: All agreed to send the protocol back for further consideration of the sentence in question.

Final Protocol Decision by Official Vote: Albertson moved, “to approve the recommended changes for the 2009 NH Patient Care Protocols brought forth today with the following exceptions: Refusal of Care sentence regarding competency, the Cyanide protocol, and the Cricothyrotomy protocol. Additionally, add to Cricothyrotomy protocol cricoid pressure until tube placement is confirmed. Sutton 2nd. Vote: Unanimously approved.

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

Coordinating Board: D Martin, Vice Chairman of the Coordinating Board, reported that the Coordinating Board has set up a subcommittee to review the required Ambulance Equipment List, which has become quite out-of-date. The first step is reviewing items they would like to see removed from the list. Later they will take up additions. Some of items on the equipment list are meds, such as activated charcoal and would require approval from the MCB. Once the committee's review is completed they will present items to the MCB for their approval.

Achilles then arrived and completed the report.

Achilles said that later today the Coordinating Board is going to pick a date for a retreat to initiate the BEMS strategic planning process. The Coordinating Board has been following through on their plan to look into medical care given by Ski Patrol providers. This agenda item actually began at the MCB. What oversight do ski patrol members have? What type of certification? Would the industry like to work with EMS towards EMS licensure for each squad? He has found that the system within the ski patrol is very similar to the National Registry for EMTs. Many also are engaging a form of medical control. Hubbell disagreed, stating that most ski areas do not even require current certification. Achilles replied that information was not consistent with the information he has obtained. Hubbell further stated that there will be a couple of very large law suits this summer over medical care issues at ski areas. He expects some guidance from the courts by this time next year. Achilles also pointed out that there was a copy of the unapproved Coordinating Board minutes in the packets for review.

B R E A K

ACEP: No report.

Bureau and Division Update: See attached report.

Discussion: Relative to emergency planning, Albertson asked in regards to the Emergency System for Advance Registration of Volunteer Healthcare Professionals, asked who would call them up? Prentiss replied most likely the local hospital would call the State OEC.

Additionally, Prentiss reported that in conjunction with Rural Health, the Bureau of EMS would be putting together some CPAP and Obstetric trainings. Hubbell informed the Board that within the next three months there would only be three OB/GYNs in the North Country and that this training comes at a very needed time.

Legislative Update: HB1594. Mason reported there had been a bill which would have provided hazmat funding through fees from entities using and handling the hazardous materials. But a lobbyist for the trucking industry, in an effort to prevent the enactment of any fees on his clients, found "unused" funds in our budget. Of course there is no unused money in our budget, but the House

passed a bill taking $1.2 million from the Fire Academy and EMS. Mason is putting together a fact sheet to correct the erroneous information that was presented before the legislature. He will be working with the Senate on this, and may need our help

HB1136 Death Benefit, there is not much movement at this time, however it is expected to be put on the agenda in the next few weeks

TEMSIS Report:
TEMSIS report presented by Schnyder – see attached
Decisions: None.

NH Trauma System: Sutton reported that the Trauma Medical Review Committee was unable to meet due to inclement weather, but will have a mini-meeting today over the lunch hour.

Other Business:
On a personal note, Prentiss wanted the group to know that her daughter, Phoebe Low, was selected to be one of the keynote speakers for New Hampshire's Annual Highway Traffic Safety Conference on April 28, 2008 in Meredith. Phoebe will be speaking to the adult audience about her experience as a motor vehicle crash survivor saved by a seatbelt.

McVicar expressed his concern with the public service announcements put out this winter by Homeland Security and the fire service recommending that everyone get out and shovel their roof. McVicar called for a show of hands of all the doctors in the room who had treated a patient injured in a building collapse. There were none. McVicar called for a show of hands of all the doctors who treated someone injured falling off a roof while shoveling it. Every member raised his hand. McVicar then asked how many had treated a dozen such patients. Most had treated a dozen. Prentiss suggested that McVicar take his concerns to Achilles who represents the Fire Chiefs Association and also Fire Marshall William Degnan. Perhaps they can work with us on a less hazardous approach and a better public service announcement for next winter.

IV. ADJOURNMENT

Motion by D'Aprix, seconded by Albertson to adjourn. Approved. Meeting adjourned at 12:10 PM

VI. NEXT MEETING

March 20, 2008 at the NH Fire Academy, Concord, NH.

Respectfully Submitted,
Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)